STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IN005324	A. BUILDING: _____ B. WING _____	07/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENE COUNTY HOME HEALTH CARE	409 A ST NE LINTON, IN 47441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments This visit was for a home health agency relicensure survey. Survey Dates: 7/14/15 through 7/17/15 Facility Number: IN005324 Medicaid Number: 200435780 Census: Unduplicated patients last 12 months: 305 Sample: Record Reviews with home visit: 6 Record Review without home visit: 6 Total: 12 Greene County Home Health Care was found to be in compliance with 410 IAC Article 17. QR: JE 7/22/2015	N 000		